MAP-9 (Rev. 12/95)

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
KENTUCKY MEDICAID PROGRAM
PRIOR AUTHORIZATION FOR HEALTH-SERVICES

1. Med. Assist. I.D. No. (Ten Digits)	2. Recipient Last Name:	3. First Name:	4. M.I.

5a: Provider Number (Eight Digits)	6a. Provider Name, Address, and Phone Number	7. Co. # of Recipient Residence:
5b. Provider Number (Eight Digits)	6b. Provider Name, Address, and Phone Number	8. Date of Delivery (if already delivered)

9. Primary Diagnosis:	11. Date of Birth
10. Secondary Diagnosis:	MM DD YYYY

Signature of Provider:	Date:	**Caution**: In order for you to receive payment, the recipient must be eligible on the date of service. **Check The Medicaid Card.**

12. Line No.	13. Procedure/ Supply Description	14. Procedure Supply Code	15. Units of Service	16. Usual and Customary Charges	17. Medicaid Action A =Approved D=Disapproved	18. Approved Amount*
01.						
02.						
03.						
04.						
05.						
06.						

19. HCB and Model Waiver Providers enter Approximate Total Monthly Charge:

$_____

DO NOT WRITE BELOW THIS LINE

20. Reason For Denial:

21. Other Comments:

22. Prior Authorization Number:	23. Approval Dates:	24. Type of Service Authorized:
Mailroom Use:	From: _____ Through: _____	40____DME 41____MODEL WAIVER 45____EPSDT/SPECIAL SERVICE 46____HOME HEALTH 52____H.C.B. 52 & 53 ____H.C.B & A.D.C 72____DENTAL ____OTHER
*Not used by H.C.B Waiver/Model Waiver		

Signature of Medicaid/Prior Authorization Respresentative:

Date: